DOCUMENT RESUME

ED 282 169 CG 019 937

AUTHOR Mosbacker, Barrett
TITLE Teen Pregnancy and School-Based Health Clinics. A Family Research Report.
INSTITUTION Family Research Council of America, Inc., Washington, DC.
PUB DATE Aug 86
NOTE 11p.
PUB TYPE Viewpoints (120)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; Contraception; Early Parenthood; *Health Facilities; Moral Development; *Parent Responsibility; *Pregnancy; *Prevention; Program Effectiveness; *School Activities; Sexuality; Student Needs

ABSTRACT

To combat the problem of teenage pregnancy, public health clinics have made birth control counseling and free contraceptives available to minors and many public schools have implemented sex education programs. Despite the development and implementation of these programs, teenage sexual activity and pregnancy have increased. The increase in adolescent pregnancy has occurred even though more teenagers are using contraceptives, using more effective forms of contraceptives, and are exposed to more instruction on sexual behavior and birth control methods. School-based health clinics, the newest form of teenage pregnancy prevention programs, are also ineffective because they, like earlier programs, are founded on three flawed presuppositions: (1) the reliance on birth control to reduce teenage pregnancy; (2) the myth of moral neutrality; and (3) the "kids are going to do it anyway" mentality. School-based health clinics should not be funded because they usurp parental authority and involvement; fail to provide moral instruction; and are ineffective at reducing adolescent pregnancy, sexual activity, abortion, and sexually transmitted diseases. In order to combat teenage pregnancy a collective strategy is needed to encourage adolescents to say "no." (NB)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

ED282169

CG 019932

A FAMILY RESEARCH REPORT

# Teen Pregnancy and School-Based Health Clinics

By Barrett Mosbacker

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

William R. Mattox, Jr.

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Family Research Council of America, Inc.
515 Second Street, N.E. • Capitol Hill
Washington, D.C. 20002 • (202) 546-5400

**The Family Research Council of America, Inc.**, is an independent, nonpartisan, non-profit research/resource/educational organization that examines social policy issues. The Council assists policymakers, scholars, government officials and the general public by providing objective analysis of issues affecting the family. The purpose of the Council is to ensure that the interests of the family are considered and respected in the formulation of public policy.

Studies from all sectors of society are pointing to facts which many have known for a long time, that the family is the strength and stabilizing factor of our culture; therefore, the family must be strengthened, reinforced, and its value to society promoted.

The Family Research Council has drawn together professionals from across the nation, in a variety of academic disciplines and professions. Council members are highly credentialed and respected in their professional communities and desire to provide their expertise and research to policy debate on family issues.

The Council has access to government decision-making centers and information sources, and is involved in providing resource persons and data to the public policy process.

The Family Research Council was established in 1982 as a tax-exempt organization. It is classified as a Section 501 (c) (3) organization under the Internal Revenue Code of 1954, and is recognized as a publicly supported organization described in Sections 509 (a) (1) and 170 (b) (1) (A) (VI) of the Code. Individuals, corporations, companies, associations, and foundations are eligible to contribute to the work of the Family Research Council through tax-deductible gifts.

515 Second Street, Northeast • Capitol Hill
Washington, D.C. 20002 • (202) 546-5400

## Foreword

In a recent article, Richard John Neuhaus of the Rockford Institute really caught my eye with this assertion: "a neo-conservative is a liberal who has a daughter in high school."

Though delivered somewhat tongue-in-cheek, Neuhaus' point (which makes indirect reference to the growing problems of teen sexual activity and pregnancy) has a lot of validity.

After all, it is not parents leading the charge for school-based health clinics, the latest proposed remedy for teen pregnancy. Instead, these clinics are being pushed by Planned Parenthood and other self-appointed guardians of teen "sexual freedom" who have consistently resisted efforts to require parental consent or notification for adolescent abortions and birth control counseling.

This is disheartening. Aside from the fact that previous contraceptive distribution programs have not worked, the imposition of these programs has raised serious questions about who is ultimately responsible for the rearing of children? Is it parents? Planned Parenthood? The school system? The federal government?

Barrett Mosbacker's excellent analysis, *Teen Pregnancy and School-Based Health Clinics,* exposes many of the dangers of allowing various social institutions to undermine the role of parents in raising children. It correctly suggests that our collective strategy for combatting teen pregnancy and premarital sexual behavior should be to help parents talk with their teens about sex and to support parents by developing programs for teenagers that reinforce the virtues of refraining from premature sexual activity.

As syndicated columnist William Raspberry noted recently:

> *Those charged with the education and development of our children have a responsibility not to abdicate fundamental values, even when they are widely ignored. That "everybody is doing it" is in the first place, not true and, in the second, no justification for abandoning our duty to say to the young people under our charge: "You shouldn't."*

I am pleased that there are now several alternative sex education curricula (such as those developed by Teen Aid in Spokane, Washington and Sex Respect in Golf, Illinois) which emphasize the value of adolescent abstinence. I just wish there were more programs in this area.

Accordingly, I hope that this report spurs an interest in developing more positive alternatives to current contraception distribution programs — alternatives that reassert parents' preeminent responsibility for helping their children learn about sex.

Gerald P. Regier
*President*
Family Research Council

# Teen Pregnancy and School-Based Health Clinics

## Introduction

The sexual revolution of the last two decades has brought about a marked increase in the sexual activity of America's youth. During the 1970s, the percentage of sexually active teens grew nearly 67 percent, and while this growth has begun to level off in recent years, there are still more than 11 million sexually active teenagers in America today.[1]

This increased sexual behavior has spurred a dramatic rise in the pregnancy rate for unmarried teenage females. In fact, more than one million teenagers become pregnant each year.[2]

To combat this growing problem, public health clinics have made birth control counseling and free contraceptives available to minors and many public schools have implemented sex education programs.

Although well-intentioned, these programs have not worked. In fact, they may have actually exacerbated the problem. In a recent report on teen pregnancy, the House Select Committee on Children, Youth & Families found that despite sex education and contraceptive distribution programs

> *there has been no change in the percentage of sexually active teens who become pregnant, but there has been a huge increase in the percentage of teens who are sexually active. And this increase in sexual activity has led to a proportionate increase in pregnancies to unmarried teens.*[3]

Why has teenage sexual activity and pregnancy increased despite the development and implementation of well-intentioned and well-financed programs?

The primary reason these programs have failed is that they are based on three flawed presuppositions:

(1) teenagers will exercise greater sexual responsibility if they have an increased awareness of sexuality and an increased accessibility to contraceptives;
(2) programs that do not explicitly encourage or discourage teen sexual activity are "morally neutral;" and
(3) teens will be sexually active even if encouraged to say "no."

*Barrett Mosbacker has worked with several organizations involved in helping pregnant teenagers. He is a member of the Family Research Council's Resource Network.*

## Contraception is the Answer?

The first presupposition undergirding current pregnancy prevention projects is that adolescents do not have enough information on the proper use of contraceptives. It is assumed that teenage pregnancy will be reduced if teenagers have easier access to contraceptives and better education on responsible sexual behavior and the proper use of birth control.

If the greater availability of contraceptives and sex education is effective in reducing teenage pregnancy, one would expect to see a correlation between increased contraceptive use and decreased pregnancies. But a study of premaritally sexually active females aged 15-19 found that as sexual activity increases, the probability of pregnancy also increases—even when contraceptives are used consistently.[4]

The contraceptive failure rate is largely responsible for this phenomenon. To quote from the Select Committee on Children, Youth & Families:

> *The contraceptive failure rate for teens who always use contraceptives is about 10% (Zelnik and Kantner, 1976 and 1979). Therefore, hypothetically, if sexual activity among teens reached 100% and the constant use of contraceptives 100%, we would still have a pregnancy rate of about 10%.*[5]

While teen contraceptive use has increased, so has the sophistication in birth control methods. According to Dr. James Ford and Michael Schwartz of the Free Congress Foundation:

> *At least as significant as the increased regularity of contraceptive use was the increased sophistication in contraceptive methods. By 1976, oral contraception had far outstripped all other methods in popularity among unmarried*

***Although well-intentioned, these (sex education and contraceptive distribution) programs have not worked. In fact, they may have actually exacerbated the problem.***

*teenagers, having been used by 58.8% of all unmarried teenage contraceptive users.*[6]

Thus, the emergence of family planning clinics has coincided with an unprecedented increase in the incidence of premarital teenage pregnancy. This increase in teen pregnancy has occurred even though more teens are using contraceptives, using more effective forms of contraceptives, and are exposed to more instruction on sexual behavior and birth control methods.

Even the largest providers of contraceptives acknowledge that the increased availability and use of contraceptives has not reduced teenage pregnancy. Planned Parenthood's own journal, *Family Planning Perspectives,* states:

*More teenagers are using contraceptives and using them more consistently than ever before. Yet the number and rate of premarital pregnancies continues to rise.*[7]

Sociologist Phillips Cutright reaches the same conclusion:

*We find no evidence that the programs reduced white illegitimacy, because areas with weak programs or no programs at all experience smaller increases or larger declines (in pregnancy) than are found in areas with strong contraceptive programs.*[8]

The anomaly of increasing contraceptive use with a corresponding increase in pregnancy rates is bewildering to researchers Melvin Zelnik and John F. Kantner:

*If all other factors had remained the same, the substantial increase in the prevalence of premarital sexual experience among teenage women between 1971 and 1976 might have been expected to result in an increase in premarital pregnancy. Over the same period, however, these same young women reported a dramatic increase in overall contraceptive use, in use of the most effective methods, and in more regular use of all methods—changes which, other things being equal, should have led to a decrease in premarital pregnancy.*[9]

Professor Kingsley Davis, a member of the board of Sponsors for Zero Population Growth, summarized the failure of contraceptives to reduce teen pregnancy:

*The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraceptive use was becoming more, rather than less, widespread and respectable.*[10]

## The Moral Neutrality Myth

The second false assumption of current pregnancy prevention projects is that programs that do not explicitly encourage or discourage teen sexual activity are "morally neutral." According to this line of reasoning, teachers and counselors merely act as catalysts of discussion and help students "discover" their own values. No moral judgments are made. While students are told it is OK to say "no" to sex, they are not told they *ought* to say "no."

***This increase in teen pregnancy has occurred even though more teens are using contraceptives, using more effective forms of contraceptives, and are exposed to more instruction on sexual behavior and birth control methods.***

On the surface, this approach is appealing because it gives the impression of being neutral and objective. It must be pointed out, however, that sex education is neither objective nor neutral. Indeed, it cannot be. It is philosophically and intellectually impossible to be morally neutral. Either sexual activity is presented as having moral parameters, or as having no parameters, but both are equally moral statements.

What is perhaps more striking (if no more harmful) is the inherent contradictions that exist in our approach to questions of right and wrong as they relate to our nation's children. No responsible teacher, parent, school superintendent or counselor would take a "neutral approach" to stealing, lying, cheating on exams or violence. Yet, this is precisely what is being done in the area of sexual activity.

Unfortunately, moral neutrality is not stagnant. Once it is accepted that teenage sexual activity is not a moral issue that can be addressed in sex education programs, there is an inevitable slide into open acceptance of such activity.

The Minority Report of the House Select Committee on Children, Youth & Families asks some very important questions in this regard:

*Every generation has inherited the difficult job of bringing children into adulthood, and the same problems have presented themselves. What is so*

*different now? Why does the problem seem so much more difficult in this generation? . . . Have we really failed in our efforts to prevent pregnancies to unmarried teens? Or is it truer to say that we have abandoned them? Progressively over the last 25 years, we have, as a nation, decided that it is easier to give children pills than to teach them respect for sex and marriage.*[11]

## Kids are Going to Do It Anyway?

Flowing naturally from the myth of neutrality is the third flawed assumption which is that "kids are going to do it anyway, so we ought to at least protect them from the worst consequences of their behavior."

It is quite true that we will always have sexually active teenagers, and consequently, unintended premarital teenage pregnancies. It is equally true that

***No responsible teacher, parent, school superintendent or counselor would take a 'neutral approach' to stealing, lying, cheating on exams, or violence. Yet, this is precisely what is being done in the area of sexual activity.***

we will always have prostitutes, drug addicts, alcoholics, wife abusers, rapists, tax evaders and thieves. The fact that some individuals will engage in unhealthy behavior should not discourage society from promoting moral conduct.

The issue is not whether some teenagers will be sexually active, the issue is whether current pregnancy rates can be reduced by discouraging unmarried teenagers from engaging in sexual activity.

In spite of the strong natural desire and propensity toward sexual activity among adolescents, sexual activity can be controlled. When one states that there has been a dramatic increase in teenage sexual activity over the last fifteen years, he acknowledges that sexual promiscuity among teenagers was once much less common than it is today. Obviously, the desire for sexual activity among teenagers has always been great, but the recent increase in adolescent sexual activity has taken place because there is an unwillingness to state in unequivocal terms that sexual activity outside of marriage poses serious risks to one's physical, psychological, spiritual, and emotional well-being.

Teen sex is not inevitable. Indeed, a recent national study found that even today, nearly half of all 18 year-old females have never had premarital intercourse.[12] Moreover 20% of all sexually experienced teenagers aged 15-17 have had intercourse only once.[13]

Although teen sexual activity has shown a dramatic increase during the last two decades, it would be shortsighted to conclude that this is an irreversible trend. Trends can be reversed if society is willing to candidly re-evaluate existing programs and make much-needed changes.

Unfortunately, when current programs are evaluated and found to be ineffective, the proposed solutions are often an expansion and modification of existing concepts rather than a total change in direction. The recent emergence of school-based health clinics epitomizes such a phenomenon.

## School-Based Clinics: An Overview

School-based health clinics have received a lot of attention recently, but the concept of offering family planning services in public schools is really not new. The first school-based clinic was opened in Dallas in 1970 by the University of Texas Health Science Center. Three years later, the Maternal and Infant Care Program of the St. Paul Ramsey Hospital opened a clinic in Mechanic Arts High School in St. Paul, Minnesota. Similar clinics in two other St. Paul schools soon followed, and the school-based concept spread to other communities throughout the country as well. Currently, there are at least 43 in-school clinics in operation and another 50 - 60 proposed clinics under consideration.

School-based health clinics vary in size and organizational structure. Some have been set up and managed by hospitals or public health departments, others by community health centers or nonprofit organizations. Almost all have been established in

***Progressively over the last 25 years, we have, as a nation decided that it is easier to give children pills than to teach them respect for sex and marriage.***

schools which are predominantly comprised of minority students.

A recent report issued by the Support Center for School-Based Clinics notes that "by definition all of the clinics are involved in family planning."[14] While

this is no doubt their primary function, clinics also offer a variety of other health services, including athletic physicals, laboratory and diagnostic screenings, immunizations, nutrition and weight reduction programs, child care, and drug and alcohol abuse programs.

By providing a wide range of services, clinic organizers believe they can not only obtain greater student participation, but that they can achieve wider community support. Indeed, Joy Dryfoos of the Center for Population Options stated in a recent article that prospective clinics "can avoid local controversy by starting with primary health care and then adding family planning services."[15]

Regrettably, this underhanded approach to establishing in-school clinics is apparently quite common. A recent issue of *Family Planning Perspectives* identified ways in which comprehensive service providers have circumvented potential opposition:

> *The most common strategy adopted to avoid opposition was to maintain a low profile—generally by keeping programs out of sight, by avoiding potentially controversial preventive services, by staying clear of abortion services, by relying on word of mouth for recruitment and by giving names to programs that obscured their functions (Cyesis, Teen Awareness, Access, Services to Young Parents, Healthworks, and Continuing Education to Young Families are some examples).*[16]

Moreover, the report states:

> *Program advocates and service providers are more or less obligated to exaggerate the potential benefits of services in order to secure political and material support. One popular ploy . . . revealed an incredible array of problems that allegedly would be solved by the provision of services for pregnant teenagers and adolescent parents. In claims reminiscent of those made for the patent medicine nostrums of the 19th century, it was argued that teenage pregnancy services would combat child abuse, crime, youth unemployment, sexual abuse, infant mortality, mental retardation, birth defects, drug abuse and welfare dependency.*[17]

## Evaluating Clinic Effectiveness

In supporting their claim that teen clinics are effective, clinic proponents often cite a study of the St. Paul schools which found that a drop in the number of teen births during the late 1970s coincided with an increase in female patronage of in-school clinics.[18]

But there is reason to question the validity of these findings. The Support Center for School-Based Clinics acknowledges:

> *Most of the evidence for the success of that program (St. Paul) is based upon the clinic's own records and the staff's knowledge of births among students. Thus the data undoubtedly do not include all births.*[19]

Moreover, an analysis of the data conducted by Michael Schwartz of the Free Congress Foundation found that the total female enrollment of the two schools included in the study dropped from 1,268 in 1977 to 948 in 1979.[20] Therefore, the reduction in reported births could be attributable to an overall decline in the female population.

***By providing a wide range of services, clinic organizers believe they can not only obtain greater student participation, but that they can achieve wider community support.***

Furthermore, it is important to point out that the St. Paul study showed a drop in the teen *birth* rate rather than the teen *pregnancy* rate. Accordingly, it is quite likely that the reduction in the fertility rate was due at least in part to an increase in the number of abortions.

As Michael Schwartz noted in a recent article:

> *We still do not know whether the rate and/or number of pregnancies changed or how many students submitted to abortions.*[21]

In addition to these problems, the St. Paul research design was not replicable and did not control for outside factors. Research analyst Marie Dietz noted:

> *Since its comparisons were done in a cross-sectional way between the school before and after clinic presence, other variables affecting birth rates could have been affecting all school populations. The suggested approach to show whether this occurred or not is to compare the clinic school with other schools or a school which is similar in school demographics (number of students, race of students, and socio-economic status of students) and to see if there is a significant difference between the birth/fertility rates of the school with a clinic and without a clinic. This was not done. Therefore, the widely publicized findings of the teenage contraceptive clinic which supposedly showed a drop in the birth rate are simply not supported by the data presented in the research report.*[22]

It is interesting to note that following the enactment of a 1981 Minnesota law requiring parental notification for abortions, the birth rate among St. Paul teenagers attending schools with clinics reversed itself.[23] This increase in the St. Paul birth rate coincided with a dramatic statewide *decrease* in abortions, births, and pregnancies among teenagers. From 1980 to 1983, abortions to Minnesota teens aged 15-17 decreased 40%, births declined 23.4%, and pregnancies dropped 32%.[24]

Not only are there serious problems with the data presented in support of the St. Paul project, but there is also substantial testimony demonstrating that clinic programs in general are not effective.

***'Program advocates and service providers are more or less obligated to exaggerate the potential benefits of services in order to secure political and material support.'***

A report released by the Muskegon Area Planned Parenthood and the Muskegon Heights Public Schools Health Clinics in Michigan found that: "There was no significant change in the pregnancy rate."[25]

Another report issued by the Support Center for School-Based Clinics acknowledged that there is a poor rate of consistent and proper use of contraceptives by adolescents:

> *Continued patient compliance poses a real challenge to health clinic practitioners. Many adolescents fail to use properly and continually a method of birth control, even after they have obtained that method.*[26]

Still another study which examined 10 localities in four states found that:

> *The comprehensive model assumes that timely interventions of health, educational, and social service agencies will help young women to make informal decisions about the resolution of their pregnancies (abortion, adoption or parenthood) . . . The scant evidence available on program effectiveness shows these to be optimistic goals.*[27]

The report concludes:

> *Comprehensive programs, despite their many virtues, are not the magic bullets that will solve the problems associated with unintended teenage pregnancy and parenthood. Nor should they be expected to do so.*[28]

## Parental Concerns and Other Problems

Not only are school-based health clinics ineffective in thwarting teen pregnancy, but many parents believe that in-school clinics usurp their authority and responsibility for helping children make decisions about sex. Once a parent gives consent for the in-school clinic to provide any health service, all student visits are confidential. Thus, parents who want their child to receive a free sports physical must sign a "blank check" which gives the in-school clinic the freedom to provide other health services (including birth control counseling and prescriptions) without further parental notification or consent.

This particular policy is not accidental. According to the Center for Population Options, it is necessary "to assure minors access to family planning information."[29] In fact, CPO is encouraging in-school clinics to compose parental consent forms so that only forms returned denying registration will be recognized as parental disapproval. Forms not returned will be considered assent.

In addition to these problems, school-based health clinics appear to be the latest step in a growing movement to transform public schools into social welfare agencies which provide a wide range of peripheral services that interfere with academic pursuits. This movement has arisen despite a dramatic decline in scholastic achievement during the last decade—a decline largely caused by the inability of public schools to give proper attention to equipping young people with basic educational skills.

***Many parents believe that in-school clinics usurp their authority and responsibility for helping children make decisions about sex.***

Myron Lieberman, writing in *The Journal of Family and Culture*, addresses this problem:

> *The educational landscape reveals a mindless commitment of public school resources to the solution of social problems that are beyond their influence. In the long run, the waste of resources, substantial as it is, may be less important than the loss of respect for public schools engendered by*

*such misguided efforts.*[30]

School-based health clinics also pose a financial problem. According to the Support Center for School-Based Clinics, the cost of clinics range from about $25,000 to $400,000 per clinic annually.[31]

***School-based health clinics appear to be the latest step in a growing movement to transform public schools into social welfare agencies which provide a wide range of peripheral services that interfere with academic pursuits.***

A study of a proposed clinic program in Mecklenburg County, North Carolina found that an average of $79,800 would be spent annually for a single clinic to serve an average of six teens per day. That breaks down to $73.88 per student served each school day.[32]

In light of the fact that school-based clinics fail to reduce the pregnancy rate, will be involved in diagnosis rather than treatment, and offer services already available in most communities through private physicians and public agencies, such wasteful expenditures to initiate and sustain the school-based clinic program seem totally unjustifiable from a fiscal standpoint.

## Conclusion

Virtually everyone agrees that something must be done to stem the rising tide of children having children.

Premature births, abortion, drug and alcohol abuse, suicide, venereal disease, juvenile delinquency, and the perpetuation of the poverty-welfare cycle are but a few of the tragic consequences of teenage promiscuity.

Unfortunately, diagnosing the problem is often easier than finding a cure. For the past 15 years, the prescribed "cure" has consisted of progressive sex education programs, the establishment of confidentiality between adolescents and various public and private agencies, and the easy access to contraceptives.

Despite 15 years of effort and the expenditure of more than $500 million, teenage pregnancy and abortion rates continue to climb.

Reacting to the obvious inefficacy of existing programs, the "experts" are now offering the "new and improved" version—school-based health clinics.

Like past programs, however, school-based health clinics fail to *simultaneously* reduce pregnancy, sexual activity, abortion, and venereal disease among our young people.

They fail because they are founded upon the same flawed presuppositions as previous programs: the reliance on birth control to reduce teen pregnancy, the myth of moral neutrality, and the "kids are going to do it anyway" mentality.

School-based health clinics should not be funded because they usurp parental authority and involvement, fail to instruct in principles of morality and character development, are promoted under the pretense of providing general medical care when their prime focus is family planning, and represent unnecessary duplication of existing services at added cost to the taxpayer.

Because our children are one of the nation's greatest resources and because their behavior will determine the type of world that will exist for future generations, we must not abandon our children to sexual promiscuity. We must renew our efforts to mold their character in such a way that they reflect virtue, self-control, and self-sacrifice in service to others.

***Teen pregnancy is merely the symptom of a greater problem—premarital, adolescent sexual behavior. Accordingly, public and private programs designed to reduce teen pregnancy should focus on discouraging sexual involvement among youth prior to marriage.***

Teen pregnancy is merely the symptom of a greater problem—premarital, adolescent sexual behavior. Accordingly, public and private programs designed to reduce teen pregnancy should focus on discouraging sexual involvement among youth prior to marriage.

Rather then presuming that teenagers are going to have sex anyway, our collective strategy for combatting teen pregnancy should be similar to the approach we have taken on curbing adolescent drug addiction, alcohol abuse, and smoking—we should encourage teens to say "no." □

## NOTES

[1]Julie Kosterlitz, "Split Over Pregnancy," *National Journal*, June 21, 1986, p. 1538.

[2]Ibid., p. 1539.

[3]Report of the House Select Committee on Children, Youth and Families, "Teen Pregnancy: What is Being Done? A State-by-State Look," December, 1985, p. 378.

[4]Melvin Zelnik and John F. Kantner, *Family Planning Perspectives*, "Sexual Activity, Contraceptive Use, and Pregnancy Among Metro-Area Teens," Vol. 12, No. 5, September/October, 1980.

[5]Select Committee Report, p. 385.

[6]Michael Schwartz and James H. Ford, M.D., "Family Planning Clinics: Cure or Cause of Teenage Pregnancy?" *Linacre Quarterly*, Vol. 49, No. 2, May 1982, p. 143.

[7]*Family Planning Perspectives*, Vol. 12, No. 5, September/October, 1980, p. 229.

[8]Phillips Cutright, "Illegitimacy in the United States: 1920–1968," *Research Reports*, U.S. Commission on Population Growth and the American Future, Vol. 1, *Demographic and Social Aspects on Population Growth*, ed. by Robert Parke, Jr. and Charles F. Westoff (Washington: U.S. Government Printing Office), 1972, p. 121.

[9]Melvin Zelnik and John F. Kantner, "First Pregnancies to Women Aged 15 – 19: 1976 and 1979," *Family Planning Perspectives*, Vol. 10, No. 1, (January/February, 1978), p. 11.

[10]Kingsley Davis, "The American Family, Relation to Demographic Change," *Research Reports*, U.S. Commission on Population Growth and The American Future, Vol. 1, *Demographic and Social Aspects of Population Growth*, ed. by Robert Parke, Jr. and Charles F. Westoff (Washington: U.S Government Printing Office), 1972, p. 253.

[11]Select Committee Report, p. 386.

[12]Melvin Zelnik and John F. Kantner, Unpublished Tabulations from the National Longitudinal Survey of Youth, 1983.

[13]Ibid.

[14]Douglas Kirby, PhD., *School-Based Health Clinics: An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy*, Center for Population Options, April, 1985, p.8.

[15]Joy Dryfoos, "School Based Health Clinics: A New Approach to Preventing Adolescent Pregnancy?," *Family Planning Perspectives*, Vol. 17, No. 2, March/April, 1985, p. 71.

[16]Richard Weatherley, et al., "Comprehensive Programs for Pregnant Teenagers and Teenage Parents: How Successful Have They Been?," *Family Planning Perspectives*, Vol. 18, No. 2, March/April, 1986, p. 76.

[17]Ibid., p. 77.

[18]Laural Edwards, et. al., "Adolescent Pregnancy Prevention Services in High School Clinics," *Family Planning Perspectives*, Vol. 12, No. 1, January/February, 1980, pp. 11, 14.

[19]"An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy," April, 1985, p. 14.

[20]Michael Schwartz, "Lies, Damned Lies, and Statistics," *American Education Report*, March, 1986, p. 4.

[21]Ibid., p. 5.

[22]Marie Dietz, Unpublished paper, "St. Paul In-School Sex Clinics," no date.

[23]Select Committee Report, p. 381.

[24]Ibid., p. 380.

[25]"Muskegon Heights School-Based Teen Clinic—A Survey," Muskegon Heights Area Planned Parenthood, September 1984—June 1985, p. 2

[26]Kirby, pp.8-9.

[27]Richard Weatherley, et. al., p. 77.

[28]Ibid., p. 78.

[29]"Annual Report," Center for Population Options, 1985.

[30]Myron Lieberman, "Sex Education," *Journal of Family and Culture*, Vol. 1, No. 4, Winter, 1986, p.58.

[31]Asta M. Kenney, "School-Based Clinics: A National Conference," *Family Planning Perspectives*, Vol. 18, No. 1, January/February, 1986, p. 45.

[32]Figures are derived from a personal letter to Jerry Blackmon, Board of County Commissioners/County Board of Health from Basil Delta, M.D., M.P.H. Health Director, April 8, 1986.